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U.S. ARMY RESERVE MEDICAL COMMAND

BY

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ABSTRACT

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Representing over 70 percent of the United States Army's medical capabilities, units of the United States Army Reserve (USAR) provide critical support on the battlefield. The American soldier and the American people entrust Army Reserve medical units to provide the best possible medical care to the sick and wounded. High quality medical care is a morale building factor to soldiers and may be the intangible element that bond soldiers to succeed in the face of adversity and danger. The National Military Strategy of the United States requires that the US Army Reserve medical units be prepared to provide support for two near simultaneous Major Theater Wars (MTW). Maintaining ready Army Reserve medical units that are capable of deploying in support of wartime missions and current operations continues to be a challenge. To meet this challenge Army Reserve leadership must understand the interlocking relationship among recruiting, retention, training and mission accomplishment. While Army Reserve medical units prepare to be ready for two MTWs, they continue to receive additional Military Operations Other than War (MOOTW) missions that further strains resources and personnel. As Army Reserve medical units move into the 21st century, it will be imperative that the USAR leadership develop innovative ways and means to meet the medical unit readiness issues.

This paper examines the history of Army Reserve's readiness issues. It argues that the essential issue for defining the success of Army Reserve medical units is in how they are organized in peacetime, and that this will define how they perform the broad range of missions in the 21st Century. It proposes an organizational structure that reorganizes medical units from the current structure and places them into a single United States Army Reserve Medical Command (USARMC). The new USARMC exercises command and control, and most importantly budget autonomy, over all Army Reserve medical Modified Table of Organization and Equipment (MTOE) units.

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U. S. ARMY RESERVE MEDICAL COMMAND

Representing over 70 percent of the United States Army's medical capabilities, units of the United States Army Reserve (USAR) provide critical support on the battlefield. The American soldier and the American people entrust Army Reserve medical units to provide the best possible medical care to the sick and wounded. High quality medical care is a morale building factor to soldiers and may be the intangible element that bonds soldiers to succeed in the face of adversity and danger. The National Security Strategy of the United States requires that the U.S. Army Reserve medical units be prepared to provide support for two near simultaneous Major Theater Wars (MTW). While Army Reserve medical units prepare to be ready for two MTWs, they continue to receive additional Military Operations Other than War (MOOTW) missions that further strain resources and personnel. Maintaining ready U.S. Army Reserve medical units that are capable of deploying in support of wartime missions and current operations requires a proper understanding of the interlocking relationship among recruiting, retention, training and mission accomplishment. As Army Reserve medical units move into the 21st Century, it is imperative that the USAR leadership develop innovative ways and means to meet the medical unit readiness issues.

To develop trained, ready and relevant Army Reserve medical units as outlined in the United States Army Posture Statement FY 00, the United States Army Reserve must develop a peacetime medical command and control structure that is organized to accommodate, and staffed with leaders who clearly understand the external and unique factors that influence, the medical community. Such an organization must utilize these influencing factors to improve recruiting, retention, and training in order to accomplish the projected missions of the 21st Century. In order to realistically achieved combat readiness in Army Reserve medical units, the leadership of the Army Reserve must take the necessary steps to develop programs that will appeal to a group within society that has high demands for professional commitment and satisfaction.

The current medical force structure, which places a large reliance on Army Reserve medical units, was designed during the Cold War for a large scale conflict and continues to have application today for a MTW. MTWs will remain part of the Army's wartime mission, but Small Scale Contingencies (SSC) and Military Operations Other Than War (MOOTW) have placed new and different demands on today's Army Reserve medical units. Missions for Army Reserve medical support have increased while maintaining unit strength has become more difficult, placing greater demands on fewer personnel. Army Reserve medical support for MTWs, MOOTWs and SSC will continue and the leadership of the Army Reserve will be challenged to provide units that are prepared to support the United States policy of engagement.

This paper examines the history of Army Reserve's readiness issues. It argues that the essential issue for defining the success of Army Reserve medical units is in how they are organized in peacetime, and that this will define how they perform the broad range of missions in the 21st Century. It proposes an organizational structure that reorganizes current medical units into a single United States Army Reserve Medical Command (USARMC). The new USARMC exercises command and control, and most importantly budget autonomy, over all Army Reserve Medical Modified Table of Organization and Equipment (MTOE) units.

THE EVOLUTION OF THE RESERVE MEDICAL ORGANIZATIONS

The history of Army Reserve recruiting, retention and training is an integral part of the Army Reserve overall history; history marked by a lack of resources and in competition with the National Guard. A small force of regulars had served the United States well for nearly one hundred years. However, as the United States moved into the twentieth century and began asserting itself in the new world order as a leader in the industrial age, the War Department needed to determine how to expand the Army to provide the means to protect nation interests. Brevet Major General Emery Upton favored a Federal Reserve of "National Volunteers," organized into skeleton battalions under the control of the Regular Army that would expand the Army in time of war.¹ In fact the US Army was on the verge of seeking this federally funded Reserve on the eve of the outbreak of the Spanish American War.² Volunteers to expand the force were favored by the Regular Army as opposed to the use of the National Guard. National Guard units, who were funded by the states and trained to accomplish state missions, were not considered to be sufficiently responsive or trained to integrate with the Regular Army. However, many of the soldiers that volunteered for the Regular Army during the Spanish American War came from National Guard units. This prompted Elihu Root, the Secretary of War, to strengthen the National Guard, rather than creating a Federal Reserve, but the Army still retained an interest in a reserve force totally under federal control.

The Army vision was for a reserve force of volunteers that would be trained to the same standard as the Regular Army under federal authority. This vision was initially implemented in 1908 with the creation of the Reserve Medical Corps. The Reserve Medical Corps were volunteer physicians that were commissioned as Army officers and could be called to active duty in time of war or national emergency.³ The United States Army Reserve considers the commissioning of physicians in the Reserve Medical Corps to be the birth of today's Army Reserve. This federal volunteer force was expanded by the National Defense Act of 1916, when the Reserve Medical Corps became part of the Reserve Officers Corps. This legislation also created an Enlisted Reserve Corps that included enlisted medical personnel. Members of the Reserve Officer Corps and the Enlisted Reserve Corps were called to active duty in 1917 and made significant contributions in the World War. In the heady nationalism of the Progressive Era and the onslaught of the war issues of recruiting, retention, training, and organization were not seen as major problems. The Organized Reserves were a welcomed and available resource.

The National Defense Act of 1916 provided for a number of other significant changes for the U.S. Army. "The Regular Army was to grow to 175,000 over the next five years and the National Guard, which was to be the first-line back up force, would grow to 400,000."⁴ To ensure the availability and quality of the National Guard force, guardsmen would take a dual oath of service. The 1916 Act further strengthened federal control over the National Guard by allowing the Regular Army to send advisors to the National Guard without seeking the Governor's permission. However, the most important change made by the 1916 legislation was that the National Guard would perform forty-eight drills per year and receive compensation. The Federal Reserve, on the other hand, was not authorized drill pay, a condition that would not change until 1948. This differentiation in duty and pay set a pattern of "lesser value" that would affect the Organized Reserve's view of itself and effect recruitment and retention.

The National Defense Act of 1920 once again redefined the structure of the Army. The Army consisted of a Regular Army, the National Guard and the Organized Reserve. The Act also divided the country into nine corps areas assigned to the headquarters of three Armies.⁵ The Organized Reserve initially was a pool of qualified and experienced personnel who had served in the World War and were to be available as individual replacements until a national draft could be conducted. It was not considered a source of trained and ready units. Administrative organizations or units accounted for and managed the individual officers and soldiers. Medical units, like many other Organized Reserve organizations, often consisted of only officers. Thus, the medical organizations became a professional and fraternal organization for the veterans and a useful association for younger physicians. Since the Organized Reserve did not receive pay for drill, this is the most likely explanation for the shortage of Enlisted Reserves. Strangely enough some officers did not want pay because this could result in a loss of volunteer status and require an obligation for mandatory, scheduled reserve participation.⁶ The pay issue and the motivation of officers to join illustrates the uniqueness of the medical community and suggests that recruitment, retention, and training issues must be addressed from multiple perspectives. For example, reserve participation among medical personnel is a matter of prestige and service as well as pay—but training activities must acknowledge their need for sophisticated development and their very busy professional lives. A potentially important factor for the Army Reserve occurred in 1922, with the Congressional Charter creating the Reserve Officers Association (ROA). Now the Army Reserve would have an advocate in Congress that could address reserve issues and support the need for resources. The National Guard Association had been created in 1879 and played a significant role in drafting the Guard favorable 1916 legislation. However, the lean years between the wars resulted in no new major reserve military legislation and the ROA's major impact did not come until after World War II. The ROA's post-war influence in obtaining appropriate resources and benefits for reserves change the readiness posture and the status of the Army Reserves, making it a more co-equal player. In the process, members of the Army Reserve incurred service obligations for reserve participation and moved into the mainstream of Army administration and bureaucratic structure.

The Organized Reserve became part of the Active Army during World War II and reactivated as a reserve at the end of the war. In the reactivation phase many hospitals became the basis of Organized Reserve medical units. While many medical personnel continued their membership in the Army Reserve, recruiting physicians became a major issue in the robust peacetime economy. One reason for this problem was Medical Corps officers of the Organized Reserve, who requested active duty during World War II, entered at their pre-war rank and, unless promoted by a unit vacancy, ended the war with the same rank. Civilian volunteers, on the other hand, were commissioned as Majors; field grade rank exceeding that of those reserves with recorded service. This inequity caused major dissatisfaction among Medical Corps officers in the Army Reserve. Promotions were offered at separation, but this incentive did not produce a strong enough appeal to retain units at the needed strength. From the perspective of the affected personnel, the belated justice could not remedy the Army's disregard of their prior service and professional military, as well as civilian credentials. This incident serves as an illustration of how organizational values and focus impact on readiness issues. Based on the observed evidence, the medical professionals saw little professional or personal advantage in peacetime service.

The Reserve Forces Act of 1952 eliminated the Organized Reserve and created the U.S. Army Reserve. This legislation also created a Reserve Forces Policy Board to provide advice to Congress on matters pertaining to the Reserve components. It established a systematic promotion system for the reserve components, but failed to provide additional resources to improve the quality of training. Membership in the Army Reserve remained low and by 1954 the drilling status of the Army reserve had fallen to 12.3 percent.⁷ There simply was not a sufficient incentive for soldiers who had completed their active duty obligation to affiliate with the Army Reserve. In 1955 soldiers were required to fulfill mandatory reserve obligations as part of the draft legislation. Unfortunately, periods of low induction from the draft resulted in low reserve enlistment, despite increased recruiting efforts. Medical units suffered along with other units from these same problems. This situation persisted until the Vietnam War when many Army Reserve units filled to maximum strength as many sought to avoid the draft and service in combat.

The Army Reserve once again reorganized in 1968. The fourteen Army Reserve Corps were eliminated and nineteen two-star Army Reserve Commands (ARCOM) were established. ARCOMs were area commands with units organized into a peacetime command and control structure. Along with this reorganization, Secretary of Defense Robert McNamara introduced the change that is the most important advancement in Reserve history for making the Army Reserve a relevant force. The Army Reserve force structure was integrated into the contingency planning process.⁸ Although contingency plans aligned units for wartime command and control, in an unfortunate oversight, or in deference to the realities of manning, administration and political realities, a situation was created in which wartrace units seldom train together. The regulatory program required wartime training guidance be provided to wartrace units, but did not resource the units for such training through the wartrace. Resources were provided through the area command, giving an area commander the effective control and major influence over training.

Aligning Army Reserve units with war plans improved the Army Reserves ability to compete for much needed resources to modernize and update equipment, but these improvements were retarded by the training resource mis-alignment and practically negated by the adverse effect on personnel readiness that occurred when the draft ended in 1973. Without the draft to supply a ready pool of personnel, the Army Reserve medical units once again experienced devastating personnel shortfalls, leaving units hollow and unprepared to conduct real wartime missions. By the 1980s, some medical estimates showed that only 1 of 3 casualties on the battlefield would receive proper medical attention.⁹ In addition, winning the Cold War further exasperated the manning and training problems. Success not only led to cuts in force structure and funding, it also undermined 50 years of reliance on Cold War threats to justify the individual commitment and sacrifice inherent to Reserve service. Unfortunately and under appreciated, the end of the Cold War unleashed a new era of internal and external strife and threats that has increased the operation tempo of the military and the risks of an actual MTW.

Historically, the Army Reserve medical readiness has always centered around recruiting, retention, training and organizational structure. More importantly, the history points to a synergy between these key elements that can lead to success or failure. A survey of this history and an understanding of its implications offers key insights into how the Army should address these issues in the 21st Century in order to provide high quality medical support in the face of new, multiple challenges.

TRANSPOSING FROM THE PAST TO TOMORROW

Today's Army Reserve medical units are being deployed at an unprecedented rate in support of a United States National Security Strategy that shapes the international environment in order to protect and promote U.S. interests.¹⁰ Ironically this aggressive strategy is being pursued at a time when active and reserve forces have been dramatically cut and substantially under funded. What the future promises is more of the same—a continuing risk of multiple MTWs and numerous and continuing MOOTWs. Army Reserve medical units are an integral and necessary part of the resources to support the National Security Strategy objectives and concepts for achieving them. However, the reliance on Army Reserve medical units to be an integral part of the policy of engagement comes with a price. A smaller, but more engaged, Reserve medical force challenges the US Army Reserve leadership to develop medical recruiting, retention and training programs that will maintain units at the strengths necessary to meet mission requirements. Clearly adequate funding is essential to success in recruiting, retention, and training, but history suggests other changes are also necessary.

Obtaining qualified medical personnel for the Army Reserve has been a long-standing and daunting challenge for the Army. The period just after the creation of the Medical Reserve Corps and during the times when the nation was at war are notable exceptions. Paradoxically, this latter exception is also true for the Vietnam War, when increases in strength occurred because reserve membership was seen as a way to keep one from having to go to war. Historically, the major negative factors that have affected recruiting during periods when the country was not at war have been the neglect of the Reserve between the World Wars; the alienation of Medical Corps officers by devaluing their pre-war service during the war, compounded by the return to peace; a period of instability and re-organization immediately after World War II; the later reorganization along administrative lines with a wartrace; the end of conscription in 1973; and, the end of the Cold War. On the other hand, a remarkable level of willing commitment continued to exist during this period founded in professional association and support, camaraderie, and national service. The present is not that much different from the past. An all volunteer force, post Cold War reorganizations, a return to a robust peacetime economy, and budget cuts (a form of neglect) are current hurdles challenging recruiting. If the negative indicators from history are valid, it is also probable that the positive indicators are equally valid and provide a basis for readiness success.

The Medical Reserve Corps first commissioned officers in 1908 and by 1916 the Medical Reserve Corps had recruited over 1,900 physicians. In the early days of the Reserve Medical Corps, recruiting was conducted by "word of mouth." The Army Surgeon General, George H. Torney, highly praised the Reserve doctors for aiding the Army in locating suitable physicians for commissions in the Army Medical Service and such service became a mark of distinction.¹¹ What is evident here is that the recognition and prestige of being an associate of this elite group was an important factor in recruiting. This also suggests that the best place to encourage word of mouth advertising is inside the organization and within the profession itself.¹² Officer and enlisted recruiting are not necessarily the same things, but within the medical community there is a shared professional competence image and relationship that suggests a comparable association and compatible recruiting patterns. The officers and enlisted soldiers of the unit know best the reason for being a member of the Army Reserve and positive word of mouth from a member of one's own profession normally has greater

credibility. Equally obvious, but under appreciated, is that current members of units already know and understand the target population. Other research supports this conclusion. Richard P. Barry of Graham Communications notes:

Studies and experience indicate that businesses see better results by focusing on a simple marketing tool, one that has been with us for hundreds of years: word of mouth. This back-to-basics approach—one that is too often overlooked—pays the most dividends for fewer dollars.¹³

The Army Reserve recently approved a plan that includes additional enlisted recruiting and civilian contact recruiters for medical officer recruiting. To support these increases in the recruiting force, new legislation has been submitted requesting increases in the current Army Reserve medical incentive programs. Additional incentive programs are essential to creating acceptable conditions for enlistment and appointments, but will not in themselves create the necessary improvements in recruitment. Within the medical profession, as history reveals, current unit members must be active in recruiting in order to effectively target and appropriately motivate new recruits. They do this by the image of the organization that they portray. The leadership of the Army Reserve must create a positive “brand image” for Army Reserve medical units and the positions they are offering. In a professional community this is accomplished by networking—word of mouth.¹⁴ Organizations such as Cadillac have long been associated with quality, and, Microsoft is known for being on the cutting edge of computer software. In a similar manner, the Army Medical Department has a long history of quality service and cutting edge medical advances in both peace and war. The combination of professional association, professional growth, and national service creates a historically attractive image for medical personnel. Such an image, of course, would have to be embedded in the organizational structure and practices of Reserve Medical personnel. “Recruiters, members, and leaders must all be sensitive to the image-live it and promote it.”¹⁵ Such an image combined with the necessary incentives to compensate medical personnel for their lost economic opportunities would solve the recruitment problem.

Retention is the flip side of the recruiting coin. As argued above, successful recruitment is dependent on current unit members. The synergy between recruiting and retention is obvious, but often difficult to grasp. Successful retention is fundamentally based on making the “image” that recruits into a reality—not an easy task! Nonetheless retention is essential. As stated in the United States Army Reserve Annual Report 1999: American’s Army Reserve Trained, Ready, Relevant, “...a fully trained, fully qualified citizen-soldier is the most precious and vital resource in America’s Army Reserve.”¹⁶ The initial cost for educating and training medical personnel, both to the individual and the Army, is extremely expensive in dollars and time. The value of experience lost when soldiers leave the Army Reserve compounds this cost. Medical personnel often require long term training to obtain the qualifications needed to meet board requirements for their specialty. And physician qualifications are based on medical school and residency requirements. The current trend in the Medical Corps (physicians) is that for every accession there are three losses.¹⁷ A successful retention program must reverse those practices that preclude officers, and enlisted personnel, from serving or the creating the dissatisfactions that cause them to leave the Army Reserve.

Here again, history offers some helpful insights. Medical personnel are healthcare professionals, who already have more work available to them than they can possibly do. The nature of this work is such that it has a societal value at or very close to that of military service. Medical personnel are not choosing between processing sales and their duty; they choose between saving lives and training to save lives. Such professionals become dissatisfied when commanders are rigid with such mundane issues as Inactive Duty Training (IDT) schedules that do not allow an absence from training. Army Regulation provides for selected Medical Corps personnel to be forgiven a selective number of IDT periods per year.¹⁸ Use of such simple provisions closes the ethical dilemma between saving lives and training to save lives. The purpose for this provision of the regulation was to offer difficult to recruit officer personnel training flexibility that would not conflict with their employment schedules. Often the same situations exist for enlisted personnel, who routinely work shifts and rotating schedules. These types of provisions should be extended to personnel that hold clinical Military Occupational Specialties (MOS) and other supporting medical specialties—a genuine dilemma exists. The Army Reserve is in a buyers' market and the Army Reserve can not afford to lose qualified medical personnel just because they have real professional conflicts. Similar issues exist with conflicting employer and family demands on a population whose commitment and work schedule are already strained. The Army Reserve must develop flexible and tailored made programs that recognize the special needs of healthcare professionals and accommodates them in order to retain mission capability.

The unvarnished truth is that the current organizational structure has lost its focus on what is really important in the medical mission and to healthcare professionals—the availability of quality medical care for American soldiers. Medical care is best provided by healthcare professionals actively engaged in their profession. Medicine, not rigid military training policy must be the centerpiece. The current bureaucratic structure is an administrative over structure that is neither fish, nor fowl. It neither administers efficiently, witness the recruiting and retention problems, nor has a wartime mission. History, as well as modern comedy—MASH comes to mind, suggests to over focus on military policies and administration is counterproductive to the practice of real medicine. Recent experience also suggests the current structure is counterproductive to creating a proper image of the Army Reserve medical units and risks not having personnel available when needed for a wartime mission. A structure more closely aligned with the realities of medical support and real missions is the next logical step in Army Reserve medical history.

In this era of personnel short falls, Army Reserve medical unit commanders have dedicated much of their time and resources to improving personnel strength, often at the cost of meaningful training. Effective training has professional value and professionally challenges the membership of the unit. Meaningful training directly relates to real missions and genuine professional needs. It has a direct effect on recruiting and retention. If the mandatory “put in your time” drill weekend is the bane of the over busy professional, it is also part of the overlooked opportunity to give life to the aforementioned positive image so essential to successful recruitment and retention. History suggests that training should be more than “drills” and include individual and team professional development. On the other hand, wartime experience validates the need for collective tactical unit training. The crux of the latter is to separate the essential from the merely mundane or unessential work—for non-productive work is the greatest sin for a busy professional. Current bureaucratic leadership has overlooked this important aspect.

The absence of meaningful training, that is training directly related to organizational purpose or image, diminishes the motivation and enthusiasm of members and devalues membership. In the movie Field of Dreams, the recurring theme was “if you build it ... they will come.”¹⁹ This theme is also true for the Army Reserve Medical units. History demonstrates that image is important to the Army Reserve medical professional, but without meaningful individual and unit training Army Reserve medical units risk being perceived as organizations that are wasting precious personal resources—the professional’s time and financial opportunities. Constructing an appropriate training paradigm for medical units is better left to a separate paper, but what is clear is that such a program is critical to giving life to the much needed image, as well as real world mission success. In 1959, psychologist Frederick Herzberg conducted studies of what motivated people to work and concluded that compensation was not the only, or even the major, reason for job satisfaction.²⁰ In fact over compensation can sometimes lead to dissatisfaction. People, Herzberg argues, need to feel that the contribution they make to the organization is appreciated and worthwhile—hence the importance of the image and the synergistic link between training and retention.

The current organizational structure is dysfunctional in regard to maximizing the value of training in building effective Reserve medical units. Presumably Reserve medical unit commanders develop training that focuses on those essential tasks that will allow the unit to accomplish its wartime mission. The commander, who is not organized under the command and control of their wartime headquarters, must be provided additional guidance from the wartime headquarters for training planning. Such guidance specifies the training requirement to be accomplished by the subordinate unit in order for the higher headquarters to accomplish its mission. When the wartrace headquarters is not the day-to-day headquarters, nor the resource provider for its wartrace subordinate, the priority for the unit’s training logically goes to the peacetime headquarters—the hand that feeds and rates it. In order for Army Reserve medical units to appropriately support national security objectives and build a compelling image for recruitment and retention, training must better focused on critical mission essential tasks. An organizational structure linking units to real world tasks and wartime missions is a logical conclusion to be drawn. Improvements need to be made in the relationship between the wartime headquarters and the units. Improving the relationship with the units’ wartime headquarters would allow Army Reserve medical units to better implement the training needed to accomplish its wartime mission.

AN ARMY RESERVE MEDICAL COMMAND

The history and the evolution of the Army Reserve reveals that recruiting, retention, and training has been somewhat problematic for the greater part of the Reserve Medical units’ existence. Since World War II incremental improvements in structure, training, and incentives have occurred, however, recruiting and retention problems have worsened. In this latter period, the fundamental framework that linked personnel to units, units to resources, and resources to training has been the area command. The history and analysis above suggests that an organizational structure that links Army Reserve medical units directly to their real world wartrace missions and MOOTWs is what is needed to produce trained, manned and relevant Army Reserve medical units. Such a structure, through appropriate prioritization of resources and focus on critical and relevant training, offers the opportunity to create an image that attracts healthcare professionals and an environment that nurtures them.

Under this concept, a single U.S. Army Reserve Medical Command (USARMC) would command all U.S. Army Reserve medical units within the Continental United States (CONUS) organized under a Modified Table of Organization and Equipment (MTOE). The USARMC replaces the area command and is the single peacetime structure responsible for aligning Army Reserve medical units more closely with the way medical support is actually provided, and, manning and training these units for contingency and wartime missions. The proposal is relatively simple in concept, but obviously harder to implement in practice.

By consolidating units under a single command, competition for resources is minimized and understanding of mission requirements is facilitated. Such consolidation allows a better prioritization of resources against actual mission training. Since the commander is a medical corps officer and his staff composed primarily of medical professionals, mission oriented training is primarily focused on individual and collective medical skills—a more proper balance between technical and tactical competencies. The US Army Reserve Command would be responsible for developing trained medical units that are ready to deploy to meet mission requirements. There currently exists within the U.S. Army Reserve structure a Theater Army Medical Command that could, with additional staffing, assume this responsibility. To maintain continuity and sustain day-to-day activities of command, a US Army Reserve Medical Command would require some level of additional full time military and civilian personnel commensurate with the additional administrative requirements.

To ensure mission readiness, USARMC would align units with their wartime headquarters and potential contingency planning partners. Obviously, one immediate planning task the command would be able to accomplish is the further aligning of subordinate units so that contingency missions and wartime trace affiliations are as compatible as possible. The contingency and wartime headquarters would provide mission input that the USARMC could translate into specific unit guidance for training priorities based on medical missions in the specific environments. Coordination and communications among the various headquarters, as well as management and administration, would be facilitated by the common medical experience and leveraged through the use of emerging communication technology. In this concept the habitual relationships needed between supported and supporting units have an opportunity to develop and flourish, albeit under the watchful and educated eye of the USARMC.

Effectively linking Reserve medical units with real world missions and supported units, and subsequently translating this linkage into individual and collective training that is meaningful to healthcare professionals, gives vitality to a Reserve Medical Corps image that can be easily embraced by the medical professional. In doing so it creates the synergy essential for manning the force. Meaningful contribution, professional development and association, and national service are an unbeatable combination for this population and, when coupled with reasonable compensation, will surely solve the recruiting and retention issues. The U.S. Army Reserve Medical Command is an obvious, active participant in the recruiting and retention process.

A national level medical command carries weight in professional medical circles and provides an enhancement to the military medical image. More than this, an USARMC can insure that recruiting and retention programs focus on the real issues and speak in a language that communicates to the targeted population. At a lower level, professionally satisfied members of Army Reserve medical units will provide

indirect or direct recruiting support by telling a “positive image” story. This will provide that critical “word of mouth” recruiting that is needed to influence health care professionals. The satisfied Army Reserve medical unit member can provide an overture into the medical community that direct recruiting has not been able to create. In essence, the key to recruiting is to develop a cohesive, bonded organization that is identified with a positive professional image.

CONCLUSION

Maintaining ready U.S. Army Reserve medical units that are capable of deploying in support of wartime missions and current MOOTW operations continues to be a challenge for the Army. As Army Reserve medical units move into the 21st Century, it will be imperative that the USAR leadership develop innovative ways and means to meet the medical unit readiness issues. Foremost among the readiness challenges is manning the medical force. To meet this challenge, Army Reserve leadership must understand the interlocking relationship among recruiting, retention, training and mission accomplishment that has made manning the force problematic throughout Reserve Medical force history. The essential issue for defining the success of Army Reserve medical unit manning is how they are organized in peacetime. The nature of this organization will also define how they perform the broad range of missions in the 21st Century. An organizational structure that removes medical units from the current area command structure and places them into a single United States Army Reserve Medical Command (USARMC) would create an unprecedented opportunity to solve the manning issue and significantly enhance mission capabilities. The new USARMC in exercising command and control, and most importantly budget autonomy, over all Army Reserve medical Modified Table of Organization and Equipment (MTOE) units juxtaposes missions, training, retention, and recruitment. While creation of the USARMC does not negate the value of financial compensations, it does create an environment where the healthcare professional's natural inclination toward professionalism and service weighs in favor of the Army.

ENDNOTES

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¹⁹Phil A. Robinson, dir., Field of Dreams, 106 min., Universal Studios, 1989.

²⁰Frederick Herzberg, The Motivation To Work (New York, NY: John Wiley & Sons, Inc.), 97.

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